HIT Standards Committee
Privacy & Security Workgroup
Transcript
January 7, 2013

Presentation

MacKenzie Robertson – Office of the National Coordinator
Thank you. Good afternoon everyone; this is MacKenzie Robertson in the Office of the National Coordinator. This is a meeting of the HIT Standards Committee's Privacy and Security Workgroup. This is a public call and there is time for public comment on the agenda and we're also recording the call so please make sure to identify yourself when speaking. I'll now take the roll call. Dixie Baker?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I'm here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Dixie. Walter Suarez?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Hi, I'm here, thanks.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Walter. John Blair? Mike Davis? Tonya Dorsey?

Tonya Dorsey – Blue Cross & Blue Shield of South Carolina
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, Tonya. Lisa Gallagher? Leslie Kelly Hall? Chad Hirsch? Peter Kaufman? Ed Larsen? David McCallie?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, David. John Moehrke?

John Moehrke – GE Healthcare
Here.

MacKenzie Robertson – Office of the National Coordinator
Thanks, John. Sharon Terry? And are there any ONC staff members on the line?

Will Phelps – Office of the National Coordinator
Hi, MacKenzie, Will Phelps.

MacKenzie Robertson – Office of the National Coordinator
Hi, Will, thanks. Okay, with that I'll turn it back to you Dixie.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, thank you and Happy New Year to everybody. I hope you all had a good holiday, good time off and I apologize for asking you to do some work over your holiday and I certainly appreciate both Walter and John's efforts at trying to give us some input that will get us started in today's discussion.

The Office of the National Coordinator has assigned a number of questions and proposed measures and certification criteria to our workgroup to respond to and I sent you that, I just extracted from the whole matrix that was distributed those questions and items that were assigned to our workgroup and those will be the ones that we'll just walk through. I included both the ones where we're the primary reviewer and the secondary reviewer. You'll recall that the last time I tried to separate them out and it kind of got confusing, so I just left them in the order they were and we'll just walk through like that.

There are also a number of questions, specific questions in the area of privacy and security that were asked in addition to the proposed measures. So, we'll just walk through all of those and today what's been distributed to you includes comments from Walter and myself and then earlier this morning John Moehrke sent out his comments, so I'll give John an opportunity to add his comments, you know, as we go along because we didn't have an opportunity to incorporate them in the materials that were distributed. So, this is a two hour meeting and we'll just make the progress as we can. Walter, would you like to add anything?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
No, no, no I think we should just go ahead.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yes.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, let's see, can we – oops that's the wrong thing; I've got the wrong thing up. Can we display the – okay, at the beginning is just the introduction so I just included that as kind of to establish the context of the whole thing but we can just move forward until the first matrix that appears, right there. Can we, let's see, I think I can zoom in myself, yeah. Okay, this objective is to use secure messaging to communicate with patients and you'll notice that in each one of these the second – is somebody moving this besides me? Huh, or is that me? I'm having trouble moving it up.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
The screen is also cutting off to the right.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I know, we can …

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Okay.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, let's see if I can get it to stop there. Okay, okay the left hand column is the Stage 2 final rule, the second column there is the recommendation. You know, whoever has control at your end it might be better if you control it because every time I try to move it you can see it jumps all over the place.

Caitlin Collins – Altarum Institute
No problem.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Maybe you would have better and then I just won't touch it.

Caitlin Collins – Altarum Institute
Which part are you trying to look at?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I'm trying to look at the very first item in the matrix, yes, and I was just trying to show that column 2 is what's being proposed for Stage 3, which is what the RFC is all about, and that is to measure more than 10% of patients who use secure electronic messaging to communicate with eligible professionals. The third column or the fourth column I guess are things that they're considering for future stages and then the last column and let me see, go across, then the next column is the specific questions and comments that they are asking us to reply to and then the last one is just the assignment.

So, the question here that we've asked to respond to is what would be an appropriate increase in the threshold based on evidence and experience? So, down at the bottom we have, maybe we should make this smaller so that you can see our responses. We have two responses; we have a comment from Walter and a comment from myself. Walter would you like to go through yours first?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Well, yeah, I mean, in this particular case I think the concern or the question is really the fact that by putting this threshold what it might mean is that providers, EPs, would need to somehow impose on patients the use electronic messaging to meet the threshold. So, the way it reads basically more than 10% of patients use secure electronic messaging, it gives the impression that, you know, somehow that 10% will have to happen no matter what and in some pieces and some markets that might not be necessarily realistic. So, I think the suggestion of changing the numerator and denominator that you provide might help address that approach.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, I think both of our comments say basically the same thing that, you know, to pose a requirement on an eligible professional over factors they really don't have any control over is really not, you know, not realistic.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Dixie?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah?

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is David, ONC has been very explicit that they have put this requirement because they want providers to aggressively recruit patients to electronically communicate with them and they are very conscious that the provider doesn't have direct control over this. This is an incentive. I mean, that has been…that is very clear in the preamble and in the current rule.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, I don't – I mean, I think, first off this is a policy question and I'm not sure what we really have to offer to it, but in terms of policy the goal is to shift patients to electronic communication and going from 5% to 10% seems like a reasonable increment. I mean, but they've made it clear they intend to actually, you know, score providers on their ability to motivate their patients to do things that ONC feels is a good idea. I mean, you can argue that that might not be good policy, but they've been pretty clear about that.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I don't, you know, and I would say all of this is policy that's where all of this is coming out of the Policy Committee, but I think that then if that be the case, if the intent is to motivate patients to use electronic communications I still think that this measure is unfair. It should be based on, you know, how many patients you have for example, how many patients are using electronic communications now and then over a period of time you could increase that by a certain percentage but to strictly make the measure that more than 10% of patients use secure electronic messaging I think is totally unfair.

I mean, in fact some patients populations, you know, depending on the disability, the age of the patients that, you know, that comprise the population that this measure I think is really, I think it's totally unrealistic.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Well, but it is an incentive program and, you know, one creates incentives that cause people to change behavior that's why they picked this measure.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But they could make the incentive, they could make the measure … I think the key point is the measure has to reflect something that the provider has control over. A provider doesn't have control over whether a patient uses electronic communications or not, they can encourage them but they can't force them.

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, they can't force them, but that's the encouragement is what it's about. I mean, if you rate a provider by the number of patients that he gets to stop smoking he doesn't have control over that either but that's a quality measure that they're rated against. So, you know, it's a measure of his ability to be persuasive, his or her ability to be persuasive. I'm just saying that it's not a surprise that they're asking providers to change patient's behavior and building that into the agenda that's already in Stage 2.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes, right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, this is just a question of whether …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And they're just asking how much they want to increase it in Stage 3.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Correct.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right, that's right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I think that's all it is. So, it's doubling of a small number.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But, whatever.

John Moehrke – GE Healthcare
This is John Moehrke.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, go ahead.

John Moehrke – GE Healthcare
Yeah, you know, I guess the discussion I agree with you and just to represent my comment I basically started with the fact that this committee is the Standards Committee in Privacy and Security and from a standards perspective there's not much to be said here, you know, clearly there could be a PHR interaction involved but that's not the question being asked. I think from a privacy, standards and privacy perspective privacy does require that a patient have access.

So, you know, I think what they're trying to do is prevent a negative, which is prevent obstruction and it's very difficult to legislate against the negative or even to write standards against a negative, or even to measure against a negative. So, you know, I don't think there's much more we can do but I agree with, you know, what David is saying is that, you know, somehow they're wanting to encourage providers to get creative at engaging the patients, but I think tying it to technology is a difficult thing, better to regulate the "what" than the "how."

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, in the question what they're really asking is how much that threshold should be increased. So, I totally agree that, you know, we really can't come up with standards that would be applicable here. So, do we want to answer the question at all, you know, do we want to recommend an increase in the threshold or do we want to just say that, you know, in terms of standards there's not much to be said here?

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is David, I'm happy with the latter, I mean, I think the policy question is going to get plenty of discussion by people that probably have a deeper vested interest than we do.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, okay then what we'll say is that we really don't have a recommendation for a standard or certification criteria relating to the standard or certification criteria here, no comment basically.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay. All right let's go to the next one, thank you. Go to the next, let's see, oops, I'm looking at my…I have two screens going here, because you can't read it otherwise. Okay, the next one is from the…this one is a brand new Meaningful Use criterion. What's IE Working Group, I don't know?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Information Exchange.

MacKenzie Robertson – Office of the National Coordinator
Information Exchange.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Oh, Information Exchange, oh, without the "h" okay. The menu objective, this would be an objective that would go onto the menu items for patients transitioned without a care summary an individual in the practice should query an outside entity. The intent of the objective is to recognize providers who are proactively querying. The certification criterion, the EHR must be able to query another entity for outside records and respond to such queries. The outside entity may be another EHR system, a Health Information Exchange or an entity on the NwHIN Exchange.

For example, the query may consist of three transactions, the patient query based on demographic and other available identifiers, so this is a query for one individual's record not the Query Health type query. Secondly, the query for a document list based for the identified patient and the third request a specific set of documents from the returned document list.

When receiving the inbound patient query the list must be able to tell the querying system whether the patient authorization is required to retrieve the records and where to obtain the authorization language. Second, at the direction of the record holding institution respond with a list of the patient's releasable documents based on patient's authorizations and third, at the direction of the record holding institution release specific documents with the patient's authorization.

So, the EHR initiating the query must be able to query an outside entity for the authorization language to be presented to and signed by the patient or her proxy in order to retrieve the patient records. Upon the patient signing the form the EHR must be able to send based on the preference of the record holding institution either a copy of the signed form or an electronic notification attesting to the collection of the patient's signature.

So, what we're having here is a query for a single patient's record and they reply with yes or, you know, yes we have some documents but then they have to have an exchange of a signed authorization before the records are provided and as you saw I had quite a few comments about this one, but Walter why don't we start with you?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah, I was primarily addressing the question that I understood was the question for the Privacy and Security Workgroup which is what is the best way to identify patients when the query is happening and particularly with respect to recommending some sort of standard. So, my point was basically that, you know, at this juncture it seems that we don't really have a single standard for best identifying a patient for which a query is being done, but today there are several methods and thresholds, and mechanisms, and, you know, ways in which one provider request the identity of the information about a patient from another provider and they send different types of data elements to try to create a match.

And so, I think, at this point it would be probably not possible to really define a single standard to identify a patient through these queries that provide, you know, the various types of parameters and combinations of multiple identity factors to allow for the identity of a patient. So, I was addressing only that part of the question I know there are other parts that really relate more to the NwHIN Workgroup that you Chair, Dixie, so I didn't address those, the other question, but only the second question which seemed to be the one that was being asked from the Privacy and Security Workgroup.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, if we scroll up a bit you can see what Walter is talking about is a specific question that was asked of us is, what is the best way to identify patients when querying for their information. John, did you have a comment about that?

John Moehrke – GE Healthcare
Yeah, well, I actually had quite a long dissertation so I'll summarize it. I very much … it very much aligns with what Walter just said in that, you know, there really isn't a single universal health identifier, of course funding is forbidden for that, but I don't even, you know, I actually explain even if there was one you still have cases where patients are dually identified and you also have cases where singles have used the same identifier. So, you have to deal with the problem whether it be a high number of problems or a small number of problems you still have to deal with the fact that there are multiple identifiers.

On the other hand, from a privacy perspective not having an identifier was supposed to help in not being able to track patients, unfortunately the result is, as Walter suggests, you start shipping to some central place high value demographics about a patient so that you can do a cross reference and thus you end up with, in my view a bigger privacy problem in that you have a central database full of demographics.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

John Moehrke – GE Healthcare
So, you know, there's really no good solution to the high level problem. I will point out and I think this is somewhat represented by what Walter said, there is interoperability standards in things like HIE, PIX and PDQ, and it was in the NHIN they use a variant that uses HL7 v3 called XCPD, but you do need to apply some regional policies to that as in, well, okay I know where to put the patient's name, but I have to be told that the first name and last name are both required. So, there is a need for things like what the NHIN Exchange did in that it nails down the policies around what information must be sent.

And then third is the matching algorithm has to be nailed down by someone, which is usually the last thing to get nailed down because of course false positives and false negatives need to be carefully managed. You know, I think, the problem that exists is that this is one of these, you know, columns that there isn't a simple answer to. The answer is you have to manage the risk of false positives against the risk of false negatives, against the risk of exposure, against the risks of wrongly identifying and thus also exposing and/or harming. So, I did include more detail than that in my response. I hope the members look through that as well.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, Dixie, this is David, I have a bunch of thoughts as well, I'm sorry I didn't …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, yeah, yeah I think everybody, I think when we discuss this in the committee will have a lot of thoughts as well because this lack of a reliable way to identify patients just keeps coming up in our full committee on just about every topic there is. So, David?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, so there are several efforts underway, some of which we all know about and some of which I can't talk about, but, yet, but several efforts on the way to address this problem, you know, with novel business practices let's just say, to address both the identity problem, managing patient identity with a, you know, I'll just say a voluntary identifier leaving the details alone for the moment, but a voluntary identifier and stuff that fits on top of some of the current standards like XDS that enables this to be a little bit simpler to support what some of us are calling the notion of directed query, which is, you know, kind of the inverse of the directed push that we addressed with Direct.

Directed query would be the patient gives the provider permission to go get the data from the other institution. A lot of details there that are probably not … I can't really talk about at the moment just because we haven't … there's a group of us trying to figure out what to do about this, but one broader point would be from the standards point-of-view is we have to be careful of not codifying an overly prescriptive approach like this document, the current proposed language looks like. I mean, it's describing a model that basically hasn't worked for a variety of reasons.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, the goal of directed query so that a provider can get the patient's record with their permission from another institution should absolutely be encouraged but by specifying it at this level of detail at this point in time anyway seems to be, you know, ill advised. In other words…

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right that was what was bothering me about it, is that, you know, they're trying to make electronic a process that doesn't work to begin with, yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah or to describe exactly how to do it even though attempt has not worked yet.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, I think the goal is terrific and I predict that over the next few years we'll see some good experiments to make it real in various ways. It would be nice if there was a standard that was so good that we could all just implement it and never have to think about it, but, you know, these barriers like lack of a national identifier, lack of a national approach to authentication those are going to be in the way, they're not addressed by the standards that we have. So, I think our comment is the goal is laudable but the standards are not yet ready for this degree of specificity.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Now both you and John mentioned that the, you know, enumerating the variables that are needed to positively identify, actually the Policy Committee held a hearing on this topic and made a recommendation maybe about a year ago I guess, right, for specific attributes that should be exchanged, exactly what John referred to as the NwHIN Exchange approach only this came out of the Policy Committee. And I don't think, I don't know that that's ever gone anywhere, probably, but would we want to go back and look at that list?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Well, so …

John Moehrke – GE Healthcare
Well, the problem with the list is that of course there are still false positives and false negatives that you would get with the list.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

John Moehrke – GE Healthcare
Which is why, you know, I in my comment, you know, added that, you know, there are plenty of good quality identifiers that we carry around with us and there's no reason not to augment that and one of them could indeed be, as David brings up, a voluntary patient ID or, you know, some other health identifier. The more of these that you can provide the more likely you get the false positives and false negatives aerate down.

But, you know, I think the concern I have with the question of, well gee since we can't do it perfectly let's not do it at all, is really a defeatist attitude, you know, I think there are indeed exchanges that are using these cross referencing systems, they are tuning on, you know, a regular basis the algorithms and the attributes, and they are converging on acceptability, you know, and to say it can't be done and therefore we should not do queries is, you know, a rather negative viewpoint.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I don't think anybody is saying that.

John Moehrke – GE Healthcare
I heard David say that.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Pardon?

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, I didn't … John, if it came out that way I'm not saying that. No, I think it absolutely can be done and it should be done, and it will be done, but I don't think this particular recipe is the way it's going to happen.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right, right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, I'm opposed to recipes, I'm not opposed to doing it.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well and I think…

John Moehrke – GE Healthcare
I apologize, David, I think there was nooks on the line, I was hearing "can't."

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I didn't express myself very well; I appreciate the fact that I was confusing. No absolutely, it needs to be done this notion at a minimum of directed query where the patient says to the provider I give you my permission to go pull my records and find a way to transmit that authorization with a query so that the remote institution says, well the patient is essentially giving me the release by virtue of the fact that this is being communicated this way. I think we can work towards that goal quite reasonably and use of an existing authoritative and strong identifier as volunteered by the patient to facilitate it as per your suggestion on your blog several years ago I think makes all the sense in the world.

If the patient says I want to share my data amongst my providers and I'm willing to give them access to a strong identifier like say a driver's license with a photo ID on it for use in that transaction then why not, I mean that makes a lot of sense. So, I think, there are approaches that can solve this problem they're just not in this particular recipe.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And it could be ultimately tied to the NSTIC certificate as well.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, but…

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
You know, the identifier that's the type … yeah, yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
So, we don't want to do, you know, maybe we want to say something about this enumerated list of attributes that came up out of the Policy Committee, because if you actually did implement a voluntary identifier then you wouldn't want there to be a whole bunch of other attributes exchanged with it.

John Moehrke – GE Healthcare
Yeah, the concern though that you have to also address, Dixie, is that an identifier is just an identifier. Once you move further away from essentially … space … what is happening today when there is patient identifier cross referencing that's based on demographics is more of an identity provisioning step that's proofing, you're identity proofing through a set of attributes. Once you start heading more towards a single identifier or a high quality identifier that doesn't have additional attributes with it you are now moving into, well okay now I need to be able to authenticate.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, so you tie it to an NSTIC.

John Moehrke – GE Healthcare
That means the patient is indeed present with that identifier and you kind of are switching from an identity proofing-like workflow to an identity authentication type workflow.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

John Moehrke – GE Healthcare
And that conversion is a not simple conversion because you're dealing again, you have to look at healthcare workflows where the patient themselves is usually not of sound body and therefore is not usually capable of being authenticated, although there are plenty of workflows especially those that are looking to use an exchange where the patient is absolutely of sound, you know, mind and is present and can authenticate, but you have to … fall back as well.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But that's why I suggested it could be tied to the NSTIC, because that NSTIC is an authenticator, it's not an identity proofer.

Mike Davis – Veterans Administration
I agree with you Dixie, this is Mike Davis, we have very low success criteria using shared identifiers with our partners, less than 20%, it's very poor because of the poor data quality of these and the inconsistencies and how they're represented across organizations. So, we're actually moving and considering moving to the use of, you know, identifiers that have a level of assurance associated with them to use in our systems and let the back end MPI worry about those kind of the correlation things, but what we want to present as the identity of the user is one that has a Level of Assurance associated with it, which is in line with what you're saying about an NSTIC kind of credential.

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is David again, or even a voluntary offering of the use of a government issued ID with a photo on it.

Mike Davis – Veterans Administration
Sure, sure, but still that's an assurance level now that we have and trustworthiness. We're putting patient consent directives in here as well and we have to have assurance that those things are true and verified and have been done correctly and can be correlated to the identities that the patients have inside of an EHR, otherwise we're going to have a denial of service or a breech.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, that's what I was responding to in my response here. I had missed the main question, as Walter has pointed out, the identity thing, but I think that in terms of the consent method being recommended here is, you know, borderline ludicrous. I think, that we should be encouraging more of a service-based consent management model wherein a patient can decide where they want to keep their consents and then, you know, the consent service is query able whether it be, you know, by other entities so that you don't have to … so that's what I was … so that a patient doesn't have to give their consent every single place that they go and then the multiple consents disagree with each other and the patient's not sure what they said where.

So, I think, it doesn't fit with this question, but I think that that's something that we could move toward and I would like to see us move toward is a model not where a patient fills out a form every place they go but where a patient selects where they want their consents managed and then there be a standard service interface to that service. I know that a number of product providers as well as service providers are moving to that model anyway. So, I would really like to see this workgroup push in that direction if not for this question then perhaps for another question, because I think it's important to do.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Dixie, this is David, I mean, I think that that may be where we end up, but I think there are simpler steps that could occur in the meantime that actually have been proven to work reasonably well, you know, for example with Surescripts where essentially consent is captured at the point of care and is communicated under a contractual guarantee by the physician who implements the Surescripts, who accesses the Surescripts service that he has captured patient's permission to release the medication history and that has worked beautifully well and it's a very simple model that doesn't get too many people upset.

And I think there's no reason why we can't extend that model or something similar to that to this directed query model where the patient's process at the point of care with the physician who says, "May I have your permission to access your record in Dr. X's site," and then said, "Yes, you may; here's my strong identifier. I've given it to him as well," and the transaction proceeds accordingly.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, Surescripts …

David McCallie, Jr., MD – Cerner Corporation – Vice President
You don't need a central service.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I'm sorry.

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, I was just going to say you don't need a central service to do that necessarily because you're capturing the decision at the point of care. Now, it certainly doesn't address all use cases, but it addresses some incredibly common use cases.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, Surescripts is one of the examples I was thinking about and I'm not talking about a centralized service I'm talking about a patient for example saying that here's my primary care provider that's who holds all of my consents go there and get them, and then that particular provider might use Surescripts as the service to manage the consents, but at least the patient doesn't have to go to the primary provider and provide one set of consents and then they go to get a mammogram and they're required to put another set of consents. Surescripts does use a service model very similar to what I'm suggesting.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But my point is that Surescripts captures that permission at each provider's location, the provider is required to …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah and that's a policy thing. I'm thinking about the standard side of things that there be someplace like Surescripts where these consents are managed and where, you know, Surescripts let's say that they would be the service, if they were the service they would look at the consents that they get and make sure that they're not incompatible.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
This is Wes, can I ask a question?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, hi, Wes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Hi. So, I'm hearing a difference in what David is saying and what you're saying when you agree with him and the way … and maybe, obviously one of my perceptions is wrong here, but what I hear David saying is that consent is not communicated and stored in a repository anywhere except possibly for history. The user is trusted to have obtained consent and what I'm hearing you say is that Surescripts maintains a repository of consents that other people can rely on to ensure that the patient has given consent. My understanding was closer to what David said, which is why I wanted to clarify this.

John Moehrke – GE Healthcare
Yeah, I agree.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, I'm not saying that you … what I'm saying … I'm trying to make it … what I envision would make it easier for patients as well. Everybody on this call knows every place you go to get any kind of health service you're asked to sign another consent form, in fact you're usually asked to sign a form that the consent isn't even on there you just sign the form that you just saw it, right?

And every place you go you don't, you know, you again sign up for consent and your consent that you sign up for at your, you know, where you get the mammogram maybe different from what's your primary care, it may be different from what you sign when you get an x-ray and I think that that's confusing for patients and I think that in terms of technology we've got the capability to enable a patient to decide here are my consents, here's what I want, this is what I want enforced and the patient could decide who they wanted to hold those consents, but then everybody else could refer back to them.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I'm not suggesting a consent repository in the sky, but rather to reduce the confusion on patients by allowing them to store the consents at one place of their own choosing and then have others query that consent repository when they need it.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Okay, so let's take that point-of-view. I would be concerned that while you might argue the process is tedious you have a harder time arguing the current process is confusing for patients, they know, they either don't care about their consent they just know they have to sign a bunch of papers or they know that each doctor that they're dealing with has separately taken responsibility for understanding their consents. I think most of them fall in the former category, but we'd like to think more would think in the latter, that's not confusing.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I wish Leslie Kelly Hall were on this call, because, you know, the consumer people say it is confusing.

John Moehrke – GE Healthcare
Yeah, I think the problem though is that the confusion comes from the regulatory policy space and trying to involve that confusion with technology is never going to work very well, really this should be seen as an action by our regulatory bodies to simplify.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes, I totally agree.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So, given …

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, this is David, this is David, I want to make one point is I don't this is an either/or in other words, I think that in the case of a competent patient who is engaged in managing the flow of their health data it makes perfectly good sense, to me anyway, that they would assert their wishes at the point of care with whichever doctor they happen to be with. So, for one doctor they may say, "Yes, I want you to fetch my records from other places" to another doctor they may say, "No, you don't really need to know any of that stuff" – that's a point of care decision a competent patient should be able to express it on the spot. That doesn't rule out the utility in the long run of a more general purpose, consent repository for example, for use in emergency situations when the patient isn't able to express their choice.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Or in the case of …

David McCallie, Jr., MD – Cerner Corporation – Vice President
So it's not an either/or.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
In the case that …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, my point is that it's too early in the industry's experience in query side of this to be so specific as the current, you know, request in front of us.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I just think we need to say it's a great goal but we must, you know, it's premature to settle on a particular recipe.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, yeah, I certainly agree with you there. I think that the level of detail that they've described here should never be specified in a regulation.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I mean, it's just …

John Moehrke – GE Healthcare
…

David McCallie, Jr., MD – Cerner Corporation – Vice President
I'm sorry, John, I just want to finish one thought with just a slight change in direction, which is I think, you know, it talks about a query for a list of documents. I mean, most of the HIEs that I've seen, which work pretty well in the world today don't necessarily just give you a list of documents they may give you other information about the patient in the form of a webpage, and, you know, may have a list of documents on there, it may have some kind of synthetic summary of the patient's activity. So, to be so prescriptive as to say it has to be a list of documents would not make sense in sort of a regulatory space.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, that's a great point. I think, the sort of the difference between documents and data has been a significant schism in how people think about health information exchange for some time now.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, I've captured here, I think that that's a really good summary actually. So, what I hear is that this should not be so prescriptive as its proposed but should allow for evolving processes around query that enable both query for documents and query for information. Is that what you said?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah and a recognition, this is David again, and a recognition that establishing patient identity, a trustworthy patient identity is a rapidly evolving space and should move as quickly as possible beyond use of mere demographics but at the moment it's not standardized enough to nail it down. I just think it's a rapidly evolving space, the use of NSTIC or other authoritative identifiers like Mike suggested or driver's license voluntarily submitted like I suggested, we don't want to rule those out at this stage of the industry.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay.

Mike Davis – Veterans Administration
Just one more point here. I have a concern and agree with the discussion that the consent should be in the hands of the provider is that the consent itself may have sensitive information in it that the patient is attempting to actually control and the consent in the wrong hands really, you know, is essentially releasing the information that the patient is trying to control.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I don't think anybody, including me, is proposing it's not to be controlled by providers. I just think it should be not distributed as it is now. But, I think, we've passed that topic. Okay, okay, so the other point is that trustworthy identity is rapidly evolving and moving beyond demographics so we should not rule out new methods of positive identification.

John Moehrke – GE Healthcare
Yeah, I might actually ask we be somewhat more positive on this and that they should encourage the, you know, use of identities, the use of consent models and the problem that we get in this market space and we've seen it already is that when ONC doesn't encourage something its seen as discouraging something.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

John Moehrke – GE Healthcare
So, you know, I might want to indicate that we should, you know, encourage the use of voluntary identifiers or additional high quality identifiers in addition, or, you know, as matching attributes, because one of the problems that we have seen with the recommendation out of the Policy Committee is that indeed there are some organizations who will only communicate first name, last name and four digit social, which is not enough to match.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay. Is everybody else okay if we use that ONC should encourage new models of identification, voluntary or new models of voluntary or other high quality identifiers?

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is David, I like that you might want to throw authentication in there as well. I think, you know, it's, you know, part of the problem, as John pointed out earlier, is just the identifier alone no matter how quality isn't very good if it can't be matched to the patient somehow.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, yeah, good point, good point, yes. Okay, good. Good discussion, thank you. Okay, back to … let's go to the next question, please. This one, I have a laptop so I can barely … no, I can't read this. So, the next one is …

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah, this is the one about the EHR must be able to query provider directories.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, yeah, this is the directory one that Walter and I had a difference of opinion on this one. The criterion is the EHR must be able to – well this is, take note, this is a certification criterion; this is not a measure. Throughout this RFC I think that that was a bit confusing because some of these are measures and then all of a sudden you get thrown a certification criterion, which is our bailiwick, so this is the certification criterion, the EHR must be able to query a provider directory external to the EHR to obtain entity level addressing information.

And the question is, are there sufficiently mature standards in place to support this criterion? What implementation of these standards are in place and what has the experience been? So, Walter, you want to …?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Sure, yeah, I mean, to the point of the question the comment that I make is that I do not see at this point a true national standard for querying directories fully developed and implemented. I mean, again, that's of today. I guess the expectation that I make there is that by the time Meaningful Use Stage 3 kicks in the standard for EHRs to query external provider directories will be, you know, developed and mature by understanding or assuming that there will be a requirement around the expectation that the EHR have that capability of querying a provider directory external to the EHR.

And the point that I make is that having that capability of the EHR being able to query an external provider directory sounds appropriate, but again, the question is whether there is a standard fully developed and in place.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Walter, I want to comment after you're through, I didn't mean to interrupt.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah, no, so that was basically my comment is that I didn't see any true national standard for querying provider directories fully developed and in use today.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I think, this is Wes, I think this is a prime the pump kind of situation not unsimilar to reporting immunization data to public health. We may go through a period where the certification is not followed by significant Meaningful Use because there is a waiver that says if you don't have a directory that you can use you don't have to do it, but getting that into the workflow of EHRs is one of the things that helps to stimulate investment and create deadlines for projects that are setting up directories.

I know California just did a demonstration at the ONC gala recently where they actually shared a provider identification between California and Oregon, I think there was one provider in the directory and the patient was the stub, but fundamentally that is something that we can urge forward, you know, if it gets to the point of the final regulation and there is no standard then it gets dropped out but it creates an expectation that there will be a standard by then and it creates a review of what have these pilots been doing and so forth, and it creates an examination of who is going to bear the cost of operating these provider directories that needs to happen.

John Moehrke – GE Healthcare
Well, this is John Moehrke and …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And my response to this was consistent with what came out of the NwHIN working group about a year ago when we, I think it was NwHIN working group, that we were asked to or Power Team, that we were asked to address provider directories, it might have been this one, I get the two confused, but I think it was the NwHIN Power Team, in that conclusion, David maybe you can help me, but, that conclusion was that the directory query is only one way that this could be done and I agree with that.

I think that, you know, that codifying in law that there has to be LDAP directory type services there for this purpose I think is over stepping the mark of what a regulation should do. You'll recall that what was suggested is that ONC explore the use of micro data for this particular purpose and I think that that's something that I still think should be done. I don't think we should lock into place directory technology as the only way that you could do this.

John Moehrke – GE Healthcare
This is John Moehrke; I'd like to point out that Meaningful Use Stage 2 already has locked in both DNS CERT Lookup and LDAP CERT Lookup. So, this is not a new criteria it is already within transport A as a mandatory certification technology. So, I agree with Wes…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So, John, are you saying that Meaningful Use Stage 2 has locked in a directory service?

John Moehrke – GE Healthcare
They have locked in a certification criteria for certified EHR technology that it must be able to query using both DNS CERT and LDAP, yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Query to get what?

John Moehrke – GE Healthcare
… query …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Query to get what?

John Moehrke – GE Healthcare
… and I agree with your point in that there is an operational criteria that is not in there.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
John, you are continually saying that the people on this committee don't understand the rules and I'd like to understand your interpretation of the rules.

John Moehrke – GE Healthcare
Sure.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
We're talking about a service to identify and get the contact, the electronic contact information for a physician; you seem to be saying that that is already locked into the regulations in Stage 2.

John Moehrke – GE Healthcare
Correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
That's news to me.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

John Moehrke – GE Healthcare
That is part of the Direct specification.

David McCallie, Jr., MD – Cerner Corporation – Vice President
John, only for the public key of the recipient not as a directory lookup.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Not as a …

John Moehrke – GE Healthcare
…

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is describing a search function, right?

John Moehrke – GE Healthcare
I don't, I mean, that's why I wanted to bring this up, because the way it is written, the EHR must be able to query a provider directory external to the EHR to obtain entity level addressing information. I'm just pointing it out.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I certainly agree with you that that's vaguely written, but we've always been interpreting it as a search function like how do I send a message to Dr. McCallie, you know, I can't remember his address let me type in his last name and see if I can find him.

John Moehrke – GE Healthcare
Right, now that – fine if that's the interpretation then, you know, there is not a mandate that I have a user interface that provides a way to make it easy to find a provider given, you know, vague information thus providing a list and therefore a pick list and all that, but that's not stated here either. So, I just wanted to back up and … because, one I agree that that could certainly be defined, but two, the comments that Wes you and others were bringing up were more on the opposite side and that is operationally am I providing a directory of my providers so that others can query it, which is not what this criteria is. And, I agree that side is certainly worth a discussion.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, this is David, my take on this would be that as per the Direct protocol and as per say Surescripts messaging that typically the directory capabilities are built in or tightly associated with some kind of a communication service and that that is likely to be the way this moves in the future, and that to propose that there should be somehow some external independent directory service is, you know, kind of like pushing with a rope. I mean, you know, we should be augmenting for communication capabilities which will drive the need for directory rather than augmenting for directory and hoping that makes communication happen.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
So, I think the focus should be on secure communication, query, push, pull etcetera and then directory capabilities will follow that and be integrated into the workflow around how those services are used like, you know, Surescripts provider directory capability is built right into the Surescripts service and it works fine inside that service. And I think it would be a mistake to try to externalize those things, because it's pushing with a rope.

John Moehrke – GE Healthcare
Well provided you don't …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, do you agree that we should find out that it's one way to do this? You know, it's not the only way to do this and, you know, this exists as a Stage 2 …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I'm saying that I don't think this should be a certification criteria at all.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I think this should be a side-effect of certifying around the way to do communications.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
As per Direct where it's built in, as John described, for validation of the public key of the recipient for fetching it not validation.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, yeah and that's what I'm saying as well only you …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, it's a side-effect.

John Moehrke – GE Healthcare
The concern …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But, I like …

John Moehrke – GE Healthcare
… bringing forward is a different concern that should be enumerated and that is…

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
What?

John Moehrke – GE Healthcare
… directory publication.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I'm sorry, John, I missed the first part of what you said.

John Moehrke – GE Healthcare
Well, I'm just pointing out I think the concern that has been raised here on the providing a directory of data for others to query is what I heard as a concern as opposed to the way it's written which is a functionality to query somebody else's directory.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, but the, the criterion as written is clearly the ability to query someone else's directory.

John Moehrke – GE Healthcare
Correct.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I'm sorry; we're looking at 102, right?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
A provider directory, I guess I'm having trouble with someone else's.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
External to the EHR.

John Moehrke – GE Healthcare
A provider directory…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, all right, okay, all right I see what you're saying.

John Moehrke – GE Healthcare
Of someone else's right?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No, no, the way I interpreted you were saying it was in another EHR's directory, but that was not what you meant.

John Moehrke – GE Healthcare
No, no but I think there is an operational concern, you know, maybe a CMS concern that organizations are not willing to publish their provider directories and therefore if you don't publish your certificates than nobody can discover you and nobody can send you…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, again …

John Moehrke – GE Healthcare
… anyway.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Again, if this … you have to look at the history of Stage 1 and Stage 2 on difficult interoperability issues. The first stage tends to be more about the technology and less about the practice of implementation and the subsequent stage tends to be to create a Meaningful Use criterion which then causes people to do the things that they need to do in order to make it work, it's almost like you can push both in the same phase because you can't push people to do something that hasn't been standardized yet and you can't get the standard out and credible in the time cycle of one phase.

So, to the extent that this is a certification criterion not accompanied by a Meaningful Use measure than I think including it in at this stage of the Stage 3 regulatory process is quite reasonable, it creates deadlines and maybe the response is that it's already been done, I think there's a lot of clarification that needs to be on that point, but it creates a deadline, it causes people to need to get clear on that.

John Moehrke – GE Healthcare
…

David McCallie, Jr., MD – Cerner Corporation – Vice President
Wes, so you're saying you would argue … the generic requirement or directory query.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I think it should be better defined all right, but…

David McCallie, Jr., MD – Cerner Corporation – Vice President
But why would you … you know, that's like saying we couldn't use e-mail until we had e-mail directories, well, you know, e-mail worked fine without directories and a few e-mail providers …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No, but I didn't take the position that … and I don't see that the language, unless it's some context I'm not aware of, takes the position that you can't do Direct without Direct directories.

David McCallie, Jr., MD – Cerner Corporation – Vice President
No it doesn't. I'm just saying that it's solving a problem that is not the primary problem, this will get solved as a side effect of the primary problem which is secure communication be it query or be it pull. For example, you could imagine, well let's say the Surescripts network and I just pick on them simply because, you know, it's up and running and unified, you know, a lot of people. You know, they have a directory capability built into Surescripts so what if a certification standard emerged that was different from what Surescripts uses would Surescripts then have to go and change to, you know, turn it into something external, it doesn't make any sense, because Surescripts service works in the context of Surescripts service.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well right now …

David McCallie, Jr., MD – Cerner Corporation – Vice President
And it works well in this context and it's provided by the service provider.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Right now …

David McCallie, Jr., MD – Cerner Corporation – Vice President
The same is significant for NwHIN. I mean, you know, providers shouldn't have to be thinking in terms of NwHIN certificates they should be thinking in terms of where's the data and how do I get it and the system should handle all of that underneath just like Direct handles the DNS CERT query or the LDAP query for you once you put the address in. So, I just think this is …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Where are you getting all of this stuff about certificates and LDAPs out of these wordings? I mean…

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, but I'm saying, Wes, my point is that necessary directory lookups are a function of what service is being provided they're not an independent capability.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yes, all right, well we've already argued, we've already agreed that Direct doesn't require Direct directories to be used. We also, I think, both agree that it could be used more broadly if it did. What I would like to avoid is the possible that there is the Surescripts domain and the Verizon domain, and the Epic domain, and people can't communicate across domains except by knowing material.

John Moehrke – GE Healthcare
… this must …

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
This is Walter I just wanted to jump in.

John Moehrke – GE Healthcare
… because this is inaccurate. The Meaningful Use Stage 2 refers to the applicability statement that was revised and the applicability statement mandates both, both DNS CERT record Lookup and LDAP Lookup and if you don't believe me take a look at the NIST Certification Test Steps and the steps include testing both of those. So …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But, they do in the same exactly. You're making exactly the same point that David McCallie is making, because in Stage 2 they're both …

John Moehrke – GE Healthcare
And Wes is saying that it's not in there.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
They're both incorporated into a communication capability.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
This is Walter.

John Moehrke – GE Healthcare
… technology is required to show it, so how is that different from what's being asked for here?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
This is the point that David I think is trying to make is here they're trying to say independent of the communication capability you have to implement a query of a directory.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Right, for purposes of finding someone's address.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right, independent of a service that you're talking about. In Stage 2 it's not independent of a service it's incorporated into the service.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yes, that's …

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
So, this is Walter, I just want to jump in, can you hear me?

MacKenzie Robertson – Office of the National Coordinator
We can hear you, Walter.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
I'm sorry, I just didn't realize if you were hearing me at all, but I wanted to point two things. One, I think we're trying to address two different questions, one is the question of the policy about the use of external provider directories, it seems that we are questioning that part first. The specific question we were asked to address, I guess or provide input, was whether there is a sufficiently mature standard in place and what is the implementation experience of those types of standards?

So, I think we can argue again, and this might be the same kind of concern about to what extent we argue the policy question and question the policy decision about requiring the EHR to have capability to query and external provider directory, that we could do and we can argue it, but I think we need to also address the question that is being asked specifically to the workgroup.

So, I wanted to make sure that we try to focus the discussion on either the policy argument of whether the provider, external provider directory is worth having, you know, EHRs have the capability to query or whether we should, you know, focus the attention on what's the status of the standards for doing those kinds of queries.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So, Walter, this is Wes, just following on the question as you posed it we have some difficulty composing that answer because we're not sure what the question is.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, what he read was the question, Wes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
What?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
The question that's been asked is exactly what Walter read. What…are there…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No, no, no what the question means, Dixie, not what the question is. We're not sure what the question means.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But, I think we can guess that it means, that it's coming from the onetime prevalent notion that lack of a national directory of, you know, addresses was a barrier to interoperability and I think some of us are saying we might have believed that at one point but we don't think that's the problem anymore. I'm saying that I should only speak for myself.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah and I'm saying that I foresee it becoming a problem at a time when, well, first of all I guess it depends on why you're saying it's not a problem. Are you saying that e-mail has survived without it for so long therefore there is no problem or are you saying the providers, the HISP providers will provide this service?

David McCallie, Jr., MD – Cerner Corporation – Vice President
I think I'm saying that the service needs to be delivered in coordination with whatever the broader communication capabilities are rather than the other way around. So, telephone directories make sense in the existence of a telephone network, you know, they don't make sense otherwise. The ability to validate a Direct certificate makes sense in the context of Direct but it doesn't make sense in the context of, you know, NwHIN.

So, I don't think that mandating that EHRs have a generic capability to do an LDAP Lookup against some unnamed source of information accomplishes very much, let's worry about what the communication models are and then assume that people that are delivering those communication services will discover whether or not they need to provide a directory, you know, as Surescripts discovered, that their directory is a fundamental part of their service.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Okay.

David McCallie, Jr., MD – Cerner Corporation – Vice President
And they invested heavily in it.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
All right, so, my concern is that if we don't create the expectation that there is a standard for looking up information based on whatever communications approach you're using that we are leaving open the potential for domination of the market by whosever biggest, often that's very hard to avoid in the real world, but I'm not…I mean, to the extent that this is what I'm saying, I'm not sure that I see the words but I don't know I'm sure what the question means, because it seems like one interpretation of the words says it's already in Stage 2 that doesn't always mean it's mature, but it makes it easier to answer the question. Another interpretation of the words says nobody's done anything like this on a nonproprietary basis.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But, in Stage 2 there's not one, there's not one standard there are actually two.

John Moehrke – GE Healthcare
Correct. Yeah, I think though, I'd like to kind of agree with what David's pointing out in that the communication's models have different needs and, you know, if you move to the, I mean, we've been talking a lot of push with Direct, you know, it's very clear you must be able to find a certificate in order to send successfully and that's SMTP S/MIME because it's asynchronous. With a query model you don't have anywhere near the same requirements, you are querying an organization for patient's information you're not querying a provider, you are yourself representing yourself as a provider, hopefully, under treatment purposes or what have you.

David McCallie, Jr., MD – Cerner Corporation – Vice President
And then …

John Moehrke – GE Healthcare
So, I think this is all so very much, I agree with David, that it's getting very specific into one particular model of communications and maybe inappropriate to other models.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And I totally agree with that, but I do agree also with Walter in that, that position, which I think is right on target addresses the policy question and not the specific question, which I think we should express, but it doesn't address the second part which is the specific question being asked here, are there sufficiently mature standards in place to support this criterion?

David McCallie, Jr., MD – Cerner Corporation – Vice President
How about, Dixie, this is David, how about if we say that the standards would be determined by the kind of communication for which the directory service is targeted.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I'll take the position that there are no sufficiently mature standards in place, because we don't have that much Direct usage, we don't have that much of the other usage except in very narrow communities and in proprietary communities neither one has really been proven sort of robust at a national level.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, DNS certainly has been.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, but …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
But DNS is a subservice of the service they're talking about here.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But we are answering the question the same way in the negative we're just providing two different reasons, right? Wes is saying that there isn't a generic standard that meets these needs and John and I are saying it really should be determined by the service that the directory is supporting therefore it's an inappropriate question.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I think the question at hand now I think is we have agreed to make a broader answer than the actual question. Do we also need to answer the specific question?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I think …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I happen to think the answer to the specific question happens to support the broader point.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yes, I think we're both answering no but for different reasons. So, it's a double no.

John Moehrke – GE Healthcare
I think it would be helpful for us to be specific in our answer so that it can be interpreted correctly. I think there's also a part of this which is separating out the various levels of standards because there are technical standards which are extremely mature but they operationally, the standards of practice and what is the directory content is not very mature for health providers.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Right.

John Moehrke – GE Healthcare
So, there's also different levels of standard's maturity as well.

David McCallie, Jr., MD – Cerner Corporation – Vice President
And there would be one other level of issue here I think that would emerge in emerge in the real world, which is if the EHRs did have a generic capability to query an unnamed directory standard that they would then have to know which of the hundreds of choices available are they supposed to query for a particular provider.

John Moehrke – GE Healthcare
Those that are operational.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, but you'd now have to have a directory of directories, right? I mean, and part of the problem is that operationally it's a very difficult to come up with a national directory of anything in healthcare. I mean, it's just very hard to do and it won't happen outside of some focused business purpose. So, again, sort of putting in the generic query capability isn't going to cause the businesses to come into existence.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
David, I agree with you and yet I argue that they should do that because as long as there is no effort people don't look far enough down the road to get to the issues you're dealing with. If you get them…it's like sending immunization information, you know, it took an entire Meaningful Use cycle to figure out that we had a bad standard, you know, that it just wasn't appropriate, it wasn't unambiguous, sufficiently unambiguous, that got fixed, all right. It's now down to how many states have things that can accept this information, but as long as the standard is an issue the business things just stay on hold, everybody has this belief that when you solve the standard problem magic will happen and the only way we seem to be able to get people to recognize that magic won't happen is by solving the standard's issue.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Oh, so, you think we should solve it to prove them wrong I mean to prove them right? I'm not sure what's the conclusion of that. I think this is the wrong lever to push on for interoperability. I don't think directories is where we should be pushing.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Directories will follow.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
All right, yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Push on the broader problem.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No, I think …

David McCallie, Jr., MD – Cerner Corporation – Vice President
…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Here's what I think, directories will follow up to the point where we get these walled gardens and there is … I'm sure there is for Direct, I don't know about the other, there's a way to poke a hole through the walls but it involves the lack of a directory service.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But the walled garden – Wes, I understand that, the walled gardens are not around directory information the walled gardens are around the communication channel itself and so the existence of a directory that notifies you that this provider's communication channel is behind a walled garden won't do you any good unless you're also behind that walled garden.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So, I misunderstand how Direct works then, because I thought ...

David McCallie, Jr., MD – Cerner Corporation – Vice President
Direct works across, you know, assuming the HISP trust each other, which is a big assumption, but assuming that they do Direct would work anywhere and a directory service might in fact be useful if you could get an actual directory service delivered. We don't have standards for a federated directory service, we're probably not going to get one because it's not a high priority item for anyone and so …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
You know, I mean, it just doesn't add enough value to emerge.

John Moehrke – GE Healthcare
The point that Wes is trying to make is though you won't get those directories without some client functionality that needs those directories. So, provided you had the ability in an EHR to say "I want to find some guy, I think his name was Wes R" you know, unless you have some kind of functionality to do that you won't have directories appear. So, you've got …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But there may be other ways to find that information.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, I'm willing to concede this. I mean, I think that we seem to be unanimous absent me; I'm willing to drop it. I think the issue will come up later, but you can't get everything on the first pass anyway.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, okay, we're going to say that the focus should be on…that directory service as an independent service … directories are … the directory service is a function of an overall, of a broader service and that the criterion should be around the broader service and not about directories per see. The focus should be on secure communications with an integrated directory service. So, we feel that this should not be a certification criterion at all.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Unless it's kind of the broader approach to a communication channel.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

David McCallie, Jr., MD – Cerner Corporation – Vice President
That is a certified channel.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, but it's not, it's not.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Right, right, yeah the way it's worded now as an independent standalone entity we think – I agree with your wording.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

David McCallie, Jr., MD – Cerner Corporation – Vice President
You know, just to Wes's point if it was presented as should all Direct HISP be required to contribute their membership to a national directory service and all EHRs be measured as to whether they can query that national directory service I might answer yes to that question because that's a directory in the context of a specific service, right?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I just don't think it makes sense as an independent service.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
And that's a real hard message to communicate to policy people.

David McCallie, Jr., MD – Cerner Corporation – Vice President
That's true.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
David, would that apply if the directory was a regional one not a national one like a state-wide level directory?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I think, Walter, that state-wide directories are having a hard time surviving the … information … at least recently not where I live or, you know, half my doctors are in Kansas the other half of them are in Missouri.

MacKenzie Robertson – Office of the National Coordinator
David, this is MacKenzie, yeah, I think your speaker phone is – we can't hear you very well, if you could pick up your handset, your headset.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Oh, I'm sorry.

MacKenzie Robertson – Office of the National Coordinator
We didn't hear any of that; you might want to repeat it.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Oh, okay, I'm sorry; I'm wearing a headset unit, is that better? Can you hear me now?

MacKenzie Robertson – Office of the National Coordinator
Much better, thanks.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Okay, sorry. No, I would say, Walter, that the regional directories might make sense I'm not sure state-based directories do simply because healthcare information doesn't restrict itself to state barriers at least in some parts of the country like where I live where we struggle …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, but we're getting way off topic here.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yes.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
You know, I think, I think what you're really – go back to Wes's comment about policy people, you know, maybe policy people shouldn't specify certification criteria because this clearly is a certification criteria not a policy and yet we are disagreeing with the policy that motivated recommending that criterion, but I think we have our answer.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Dixie, does it make sense to say something that, well, never mind, I think we've said enough, never mind.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well if you want to … I'm still here.

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, no I don't have anything to add.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
All right, okay, all right, let's go to our next one which is IEWG 103, right there. This is an existing, this is, let me see, this first column – okay, that's the first column is the final rule, okay. So, their question, the certification criterion has to do with the user creating, electronically creating a set of export summaries for patients and they ask what criteria should be added to the next phase of EHR certification to further facilitate healthcare provider's ability to switch from using one EHR to another vendor's EHR, which is only remotely related to the criteria, but …

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Walter?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yes, exactly, that was my comment I didn't really quite get this question based on the, you know, certification criteria that this was arguing, but nevertheless, to the point of the question the concern that I expressed in my comment anyway was that, you know, the adoption and implementation of an EHR entails many processes, many steps, many things that go way beyond simply standards and interoperability, there's a whole host of things like from installation to customization, training, workflow processes, etcetera.

And so, attempting to establish standards in all these areas but really getting to internal and operational levels to try to facilitate an organization to install and then be able to switch or de-install, uninstall and then change to a … install a new one seems to be, you know, inappropriate.

David McCallie, Jr., MD – Cerner Corporation – Vice President
This is David …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I need to respond to that, but Dave, you go first if you want.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Well, just to Walter's point, I think, this is specifically addressing the issue of migrating the patient's data not migrating the other system components. So, you know, if you want to convert your checkbook balancing from one provider to another you need to be able to export your checkbook registry or something and this is along those lines, just the patient data, how would you move patient data from one system to another.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, that's not what the question says at all.

David McCallie, Jr., MD – Cerner Corporation – Vice President
How does it … then? It seems to say that.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
It says that, I mean, why do you say that the question – what do you say the question says, Dixie?

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, what do you think?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I think it says how do you switch from one EHR product to another.

David McCallie, Jr., MD – Cerner Corporation – Vice President
No, just enable a user, the certification criteria would be to enable a user to electronically create an export, a set of export summaries for all patients in the EHR formatted according to a whole bunch of details. So, would you be able to create an export summary and the assumption is that the other EHR that you're switching to would have an import capability that would pull that data in and you would have migrated your patients from one EHR to another, the data about your patients. So, I think it's very clear.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, yeah and I mean, I think, that we know of a vendor right now that, at the conclusion of Stage 1 cancelled a product and the vendor offers another product, there were contractual requirements to make data available but the problem of those contractual requirements is always that it's in a format that only the vendor can interpret and the vendor basically created such a discount for their other product just for the process of transferring the data over not the actual price of the product that they created a Hobson's choice for their users in terms of going to their other product.

I think one can argue that there's a lot of things that go into the cost of switching but, you know, having to redo all the configuration, retrain all the users, figure out, you know, what problems you don't have to work around that you did in the first one and what problems you do have to work around in the new one that's all part of the install process, not much can be done about that, but the cost of recreating patient data or losing it is a significant cost and perhaps the most significant cost and it can be addressed. They're implying that there's already something in Stage 2 about this is that right?

John Moehrke – GE Healthcare
Yes.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
No.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I think they're trying to leverage the transition.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Oh, is this…

David McCallie, Jr., MD – Cerner Corporation – Vice President
Leverage the transition of care.

John Moehrke – GE Healthcare
This is already in Stage 2.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, this is Stage 2.

John Moehrke – GE Healthcare
This here is already in Stage 2.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, all right.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, not the migration isn't.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
What's in Stage 2 is only the enabling the user to electronically created a set of export summaries.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Right, okay, so, our first comment is that a corresponding import requirement would be very helpful in terms of enabling; well I was looking for their wording here …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Oh, I see what they're getting at …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
But …

David McCallie, Jr., MD – Cerner Corporation – Vice President
… what additional data fields would facilitate the…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Right, yes.

John Moehrke – GE Healthcare
Yeah, they're saying of the null set what is not included in a CCD.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Right, right, right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I'm sorry why are you saying null set, John?

John Moehrke – GE Healthcare
Actually I meant to say of the infinite set.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Oh, okay.

John Moehrke – GE Healthcare
It came out wrong, sorry.

David McCallie, Jr., MD – Cerner Corporation – Vice President
They're proposing the addition of encounter diagnoses, cognitive status, functional status and discharge instructions. So, you know, it's trying to further increase what's in the full transition of care summary and saying …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But changing form a … I'm sorry.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Well …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I think these are all Stage 2, right?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
They're asking us in addition to these …

John Moehrke – GE Healthcare
Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
What would…and that's a functional question.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But if you're changing products, I mean, they're clearly switching from using one EHR to another vendor's EHR you're not just exporting and importing summaries, you need to export and import all of the data.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I think that they're, I think that the reasoning today – first of all the whole thing is unclear because there is apparently not an import requirement, but …

John Moehrke – GE Healthcare
Well, there is an import requirement for CCDs.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But that's an import …

John Moehrke – GE Healthcare
They're talking about both import requirements.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Wes, this is one of, this is you're, you know, if you build it they will come kind of argument, right? If all the vendors must implement an export than those vendors who are looking for new business will of course implement an import.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, all right, I'll accept that, okay.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
But they will import only a care summary and I'd like to hear the answer to my question, that still wouldn't be sufficient to migrate from one EHR product to another.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Well, I think from a patient data point of view there are many places that probably would consider that adequate, maybe not adequate but sufficient, not perfect but sufficient. So, for example, when we pull data out of existing systems that, you know, a convergence from a home brewed system to our system or whatever, we rarely import everything, we import summary data and some recent data depending upon the client, but you don't import everything. And maybe in the future we should import everything, but I don't think it's an absolute given that you have to import everything. So, I look at this as a question of what's the definition, what's the proper definition of a C-CDA template that should be used for exporting of data sufficient for moving the patient to a new record.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes, yes, I agree it's not a summary though, you know, it is at the very least its recent data.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I mean, and it's, yeah, so it's a definition of a template and it needs to be worked out and, you know, I think it's probably an S&I-like discussion of what are the right fields to be in that template that should be used for the purposes of moving a patient's record to a different vendor, it's just kicking the can down the road.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well I agree with everything that's been said and I would like to add to it, that it is a balance between sufficient and perfection.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Right.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
In other words each – first of all, there should be no … and I think the way this is worded it's fine, but there should be no data that's required to be structured for this export function that also isn't required to be structured for other functions that create data to send it. I mean, you shouldn't say, well, chest x-ray observations have to be structured here unless you're saying they have to be structured in other ways of sending data as well, because that presumably is this minimal set that everybody's going to focus on. So, I think this needs … this is a very … this is a question of balance, it takes … I think to suggest an I&S look into this is the right answer.

David McCallie, Jr., MD – Cerner Corporation – Vice President
S&I you mean?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
S&I, yeah.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Oh, I thought internal …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Immigration and Nationalization Program.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Immigration and Nationalization.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Oh, INS, right.

John Moehrke – GE Healthcare
Yeah, I'm not exactly sure …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well we've got self-exporting data right, yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, self-exporting data.

John Moehrke – GE Healthcare
Yeah, I think, you know, again, I think the first point I'd bring up is, you know, being the Privacy and Security Workgroup I'm not sure we have, you know, much expertise there. It sounds far more, you know, in the space of clinical than not. I would, however, you know, stress as has been said somewhat I think that you probably get diminishing returns as you start to mandate that the whole industry in the US has to have a capability, you know, I think this is probably sufficient and to go beyond it, you know, there better be good justification why everybody has to do it.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I mean, I just think that this is a question that, you know, the balance between the probability that someone is or isn't locked in by a specific data element versus the cost of having that data element coded in a standard format is hard to answer. I would say as the security group are there any particular kinds of data about patients that we would like to see on this list if it were practical, so consents comes to mind that…and I think we could, this group could give a productive answer in that regard.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well we tend to …

John Moehrke – GE Healthcare
And I did enumerate, I did enumerate some of those like consents, authorizations, accounting preferences, provenance, restrictions. The question becomes are those still valid in the new system as they would have been in the old system and that's not clear to me that they would still be valid.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah and …

John Moehrke – GE Healthcare
I realize that consents are usually given and authorizations are given to an organization not a technology.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Right.

John Moehrke – Interoperability & Security – GE – Principal Engineer
But they probably were formed in a way that the technology can support and the new technology would have different ways of supporting a new policy so they may not even be appropriate in the new system.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, okay, that's a good answer.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But I think wouldn't we – I think we are in support of the notion that this is a CDA template that needs to be worked out that defines what is that proper tradeoff between exporting of everything versus exporting of stuff that's reasonable.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, I mean, as I'm reading the comments here the two commenter's don't believe this is an important issue apparently.

David McCallie, Jr., MD – Cerner Corporation – Vice President
I think it is.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I disagree entirely. I think that one of the biggest problems in all programs of government standardization is that they're seen as constraining competition and we know in IT that holding the data hostage in the way the users put it is in fact an issue, whether it was done on purpose or not, that increases the cost of switching enormously.

So, I think that we should not say anything in our response that poo poo's the idea of doing this and I think we should further suggest that the specific answer takes some substantial analysis and tradeoff between the value of functional importance of the data and the standards necessary to represent it and should be carried out by a separate process.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well, I think that, I think that we should also recommend in our response, make sure that we address only the ability to export and import data. I think, the way that they're question is worded suggests that we make … would undermine competition. I don't think that it should go beyond the data.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, I think that's what they intended but we can clarify that part.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, all right, so, I mean, I can think of another thing that I'd like to see on this list in a perfect world which would be clinical decision support rules now I don't think that's practical.

John Moehrke – GE Healthcare
How about provider directory?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
What?

John Moehrke – Interoperability & Security – GE – Principal Engineer
A user base, right? I mean, that's another thing that's often…

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well people often buy a different system because they want a different user interface. I mean, frankly, you know, the CIMI work would go a long way towards being able to export templates that are used to create the major information structures of the user interface, but I just don't think any of that is practical in the timeframe of Stage 3.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Right and this…

John Moehrke – GE Healthcare
And this is more the user directory with the users and their roles assignment.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah.

John Moehrke – GE Healthcare
That would be under the authorization, now that's another thing that often times is too tightly coupled inside of an EHR and again, you know, you'd have to recreate it if you couldn't export that.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
So there's an example really appropriate and frankly there's a whole business of doing screen scraping to get that data out of one system and put it in another right now. I mean, it's ugly but it happens. I think that's a good example, but I think the most important thing is to recognize that this is important and that it takes further evaluation in order to answer the question.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, I agree, I agree. Okay.

David McCallie, Jr., MD – Cerner Corporation – Vice President
But we like in general the notion that it would leverage the CDA as the means for the patient data, right? I mean, can we be supportive at that level?

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yes, we can.

David McCallie, Jr., MD – Cerner Corporation – Vice President
We don't have to invent a new export format we just have to decide which CDA fields …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Assuming that 17205a3 is the right answer than that answer is then yes.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, we don't need to start from scratch here we've done enough work to make CDA work that we should stick with it.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Right.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
At least …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I don't know, just without going back and looking I don't know that that's implicit in these specific citations, because there are citations, separate citations for code sets and for formats.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Well and what if the two products used the same DBMS and you could just set up the same data model and the same product …

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well, unless they use the same …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And you could just do, you know, a switch over into the new.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
No, I mean, unless they use the same schema, the same business rules.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
That's what I just said.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
The same …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, that's what I said.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
You said the same DBMS that's like saying …

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
No I said the same DBMS and the same data model.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Yeah, so there are no two vendors that do that, but I think this doesn't rule out other methods this just says this would be a certification requirement that you can produce this kind of a template that to make it realistic you need other specifications like how do you define the list of patients to be exported and, you know, I mean, so this is not a sufficient spec but it seems like it's a start that is a modest incremental work.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah.

David McCallie, Jr., MD – Cerner Corporation – Vice President
And it does, I think create a – it does address the business problem of lock in which is perceived to be a problem, I don't know how big it is, but it's perceived to be a problem.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, let's see, we perhaps have time for one more.

David McCallie, Jr., MD – Cerner Corporation – Vice President
Dixie?

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes?

David McCallie, Jr., MD – Cerner Corporation – Vice President
I was just going to say if it's an easy one.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah, yeah, this is an easy one, to improve the safety of EHRs should there be a meaningful use requirement for providers to conduct a healthcare IT safety risk assessment? Are there models or standards that we should look to for guidance? Well, this is the first, I think, of the questions that were asked of us. Okay and Walter?

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah, I mean, I think my point I make in my comments is that I think it would be appropriate to expect that safety be made an integral part of conducting an overall health IT risk assessment, but at the same time I do not believe there is an operational model in place that can be truly followed to achieve this goal in the sense that, you know, we're just beginning to look at the safety of health IT overall and so I don't think there are models or standards that can provide the guidance that is needed at this point, but I think they will be developed as we move towards Meaningful Use Stage 3 and particularly as the FDA begins to develop the framework for establishing a safety of health IT regulatory environment. But today I don't think we have truly a model to follow for how to conduct a safety risk assessment of health IT.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Well let's answer the …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
I pointed out that, you know, the fault-tree analysis, reverse Petri-net analysis are commonly used for – they have their grounds in devices, safety assessment, but they're also used in software safety analysis so there are methods that have been used but they're usually geared either toward devices or control systems, they're not really geared toward a complex system like an EHR. And that in this case it probably, this type of an EHR safety risk assessment would be very similar to what we do for security except that you would look for hazardous conditions that threaten human lives versus threats to information confidentiality, integrity and availability. I think it would be an appropriate thing to do.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah and I think we are both agreeing that it should be…that the safety component should be made part of an integral and more comprehensive health IT risk assessment that includes safety, security and others.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yeah.

John Moehrke – GE Healthcare
And this is John, I sent this morning in my comment, there actually is a specification IEC 800001 which is targeting the same space for medical devices being integrated into the hospital network. So, there is something but its right now specific to things that are declared as medical devices.

Dixie B. Baker, MS, PhD – Senior Partner – Martin, Blanck & Associates
Devices, yeah, that's the same.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Let me ask a question. If you look at the HIPAA Security Regulation it's not very specific, in fact, the real, one of the real issues in terms of doing a security program is figuring out what is the right level to interpret it, what are the specific vulnerabilities and measures that you have to look for and I don't think that this is much more than just creating a similar kind of requirement over years that, you know, some standards may develop or some organizations like High Trust or somebody else may propose standards that the industry finds either gets them through audits or doesn't, but I don't think it takes a lot of standards to make this a criterion.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Yeah, I mean, I think we're all saying the same thing, Wes, right? I mean we're saying this makes sense, this should be made part of a risk assessment, perhaps right now there isn't a concrete set of specifications such as the ones that we have for security under HIPAA the 42 implementation specifications, but developing something like that for safety, for risk assessment of the safety domain would be, you know, appropriate and feasible.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Yeah, I'm looking at their second question there which says are there models or standards that we should look to for guidance.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
And there are. There have been software safety forever, but there are also…it seems to me that, you know, there are certain security risks that are also safety risks, like, you know, HIPAA also … HIPAA requires a risk assessment but it also requires a criticality analysis and safety could be brought into both of those, you know, without doing, you know, looking at the typical, you know, Petri-net analysis, fault-tree analysis type thing.

For example, denial over service attacks, you know, and even intrusions depending on the type of data, you know, you've probably heard me talk about one time I did a penetration study that was really looking at penetrating a provider's system where they stored all of their clinical guidelines, you know, and if you could get into that system and change the clinical guideline that's a safety risk. So, incorporating safety risks into risk assessment and criticality analysis I think is the first step toward doing this.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Can I just ask isn't that redundant? I mean, aren't you already … aren't all of those things; I mean the things you're describing, which are risks that a failure … that arise from the failure of security measures are already addressed by HIPAA. I mean …

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
No they're not, they're not. Let me tell you, let me tell you why. It's because the clinical guidelines are not PHI, so a risk assessment under HIPAA wouldn't even look at the protection of clinical guidelines.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
Okay, that's a good comment.

John Moehrke – GE Healthcare
Yeah, it very much depends on how mature your organization is and how much they look at the issue as an overall…the other piece of it is that the domain of risk, which is security is infused from an mechanic perspective the same as from safety or privacy, but the domain of how do you evaluate this, you know, how bad is it so to speak if that particular risk happens is a very different measurement evaluation process.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
It seems like one step might be to identify the type of data besides PHI that might be safety relevant or safety critical data like clinical guidelines, like clinical decision support rules, you know, those things are not PHI but they're certainly safety relevant.

Wes Rishel – Vice President & Distinguished Analyst – Gartner, Incorporated
I think that's a good thing to put into the answer. I think, that we would also argue that a general requirement to do a patient safety risk analysis, based on the functionality of the system, is reasonable to ask under the assumption that the criteria for that will evolve over time just as they have for HIPAA.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, that's what we will say. Okay, we're approaching the end of our time. MacKenzie, why don't we open for public comment?

MacKenzie Robertson – Office of the National Coordinator
Sure and just to remind everyone we also have the call on Friday.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Yes and we will record responses to as far as we went today. I think we've made really good progress today, so thank you all for dialing in and your participation.

Public Comment

MacKenzie Robertson – Office of the National Coordinator
Okay, operator, can you please open the lines for public comment?

Caitlin Collins – Altarum Institute
Yes. If you are on the phone and would like to make a public comment please press *1 at this time. If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. We do not have any comment at this time.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Okay, again, thank you all for dialing in today on probably for many of you your first day back in 2013 and for those of you who haven't looked at, you know, done your review of the RFC I would appreciate you, if you have any inputs to the remaining questions, to send your comments to us, we appreciate it. So, with that have a good day.

Walter Suarez, MD, MPH – Kaiser Permanente – Director of Health IT Strategy
Thank you, bye-bye.

MacKenzie Robertson – Office of the National Coordinator
Thanks, everybody.

Dixie B. Baker, MS, PhD – Martin, Blanck & Associates – Senior Partner
Bye-bye.